STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004904	A. BUILDING _____ B. WING _____	05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HOUSE	297 S 100 E WASHINGTON, IN 47501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaint IN00105243. Survey dates: 05/01/12 and 05/02/12 Facility number: 004904 Provider number: 004904 AIM number: N/A Survey team: Sharon Whiteman RN TC Susan Worsham RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 07 Emerald House was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality review 5/03/12 by Suzanne Williams, RN	R 000		